



Submitted via Federal e-Rulemaking Portal: <https://www.regulations.gov/>

William Parham

January 20, 2026

Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services

Re: Bid Pricing Tool for Medicare Advantage Plans and Prescription Drug Plans (CMS-10142)

Mr. Parham,

Elevance Health appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed information collection under U.S. Office of Management and Budget (OMB) Control Number 0938-0944 (CMS-10142), related to the Medicare Advantage (MA) and Part D Bid Pricing Tool (BPT).

Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. The company supports consumers, families, and communities across the entire care journey – connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve more than 109 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions.

These comments focus on the proposed supporting documentation requirements for capitation and risk-sharing arrangements, specifically Supporting Documentation Item 23.2c. We support CMS's goals of transparency. We are concerned that the proposed approach for Item 23.2c would impose substantial and unnecessary burden with limited value and is not justified under the Paperwork Reduction Act (PRA). The additional administrative effort required to comply with these requirements would not improve beneficiary-facing information and may divert resources from activities that more directly support beneficiary value.

Support for Items 23.2a and 23.2b

We support CMS's expectations under Items 23.2a and 23.2b:

- Item 23.2a (high-level descriptions of provider arrangements, with the ability to group similar arrangements) is reasonable and feasible.

- Item 23.2b (a narrative and numerical demonstration of methodologies used to allocate risk-sharing payments to service categories, with representative examples by methodology) appropriately balances transparency with operational flexibility.

These elements allow CMS to understand how arrangements function and how allocations are performed.

Concerns with and Recommendation for Item 23.2c – Allocation Across Each Associated BPT

As proposed, Item 23.2c would require numerical support showing how risk-sharing payments are allocated across each associated BPT for each individual provider arrangement. This requirement raises several concerns, which we detail below.

1. Required information does not exist in the proposed form for the projected period

For many MA organizations, risk-sharing is not calculated as a single, provider-level “total gainshare” that is then allocated across BPTs. Instead, projected risk-sharing impacts are calculated independently within each BPT by applying projected contract terms to the claims and utilization underlying that bid. In these cases, there is no aggregate provider-level gainshare amount in the projected period to allocate.

Requiring plans to create a synthetic provider-level total solely for reporting purposes would compel the creation of new data constructs that are not used for pricing, financial management, or operations. As currently designed, the BPT does not contemplate requiring regulated entities to generate information that does not otherwise exist or serve a functional purpose.

2. Circularity and cascading recalculation risk

Imposing a requirement to calculate and then allocate a total provider-level gainshare across multiple BPTs would introduce circular calculation issues. Allocations would affect bid-level revenue and costs, which would in turn change the total provider gainshare, necessitating further reallocation. Even small changes to assumptions, benefit designs, or desk review adjustments in one bid could trigger cascading recalculations across multiple bids and, in some cases, across multiple contracts.

This circularity substantially increases operational complexity and risk without, based on our understanding, an analytical benefit to CMS.

3. Disproportionate burden relative to incremental value

The proposed approach would require plans to replicate detailed provider economics calculations that are typically performed by specialized internal teams and systems. Reproducing those calculations in a CMS-prescribed format, potentially including implied expectations to reconcile to other BPT worksheets or document contractual mechanics, would be a major undertaking.

At the same time, CMS already receives meaningful insight through:

- High-level arrangement descriptions (Item 23.2a), and
- Demonstrated allocation methodologies by service category (Item 23.2b).

The incremental value of provider-by-provider, BPT-by-BPT numerical allocations is limited, while the burden is significant.

4. *Applicability varies by plan design*

Allocation of base-period gainshare across BPTs may be more relevant for organizations that explicitly use base-period allocations as the foundation for contract-year projections. For plans that do not do so, applying the same documentation standard in both the base and projected periods is unnecessarily rigid and misaligned with actual pricing practices.

Recommendation: To address these concerns while preserving CMS's oversight objectives, we respectfully request that OMB condition approval of this collection on CMS clarifying or narrowing Item 23.2c in one of the following ways:

- Limit Item 23.2c to the base period only, with no prescribed format and no requirement to demonstrate calculations beyond the allocation itself.
- Permit submission of a single representative example per allocation methodology, rather than provider-by-provider submissions.
- Allow plans to attest, where applicable, that projected-period risk-sharing is calculated at the BPT level and that no total provider-level gainshare exists to allocate, with reliance on documentation provided under Items 23.2a and 23.2b.

Any of these approaches would support CMS's ability to understand and review risk-sharing arrangements, while materially reducing burden so plans can continue to focus resources on activities that support beneficiary value.

Concerns and Recommendation Related to the CY2028 Service-Type Allocation Proposal

Elevance Health also has concerns about CMS’s proposal, beginning in calendar year (CY) 2028, to require risk-sharing payments to be allocated based on the specific types of services a provider directly furnishes. This requirement would obligate plans to create and maintain detailed provider-level mappings of service types by geography and contract and link those mappings to claims and BPT service categories. For many plans, this information is not otherwise used or maintained for pricing purposes. Implementing this requirement would require new systems and overly burdensome ongoing manual processes across thousands of providers, with limited incremental value to CMS review.

More generally, we are concerned that increasingly prescriptive reporting requirements may limit plans’ ability to apply reasonable, actuarially sound assumptions that align with their business models, data structures, and pricing processes. When multiple methodologies can produce reasonable and auditable results, flexibility is important to ensure that information collections remain practicable and do not impose unnecessary burden.

Recommendation: We request that OMB consider whether this requirement is necessary and that CMS retain flexibility rather than prescribe service-type–based allocation requirements.

We value the partnership that we have developed with CMS and welcome the opportunity to discuss our comments. Should you have any questions or wish to discuss our comments further, please contact Jeremiah McCoy at 202-302-4028, or jeremiah.mccoy@elevancehealth.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth P. Hall".

Elizabeth P. Hall

Vice President